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Improving the Oral Health of School-Aged Children: Strengthening School-Based Dental Sealant Program Linkages with Medicaid/SCHIP and Dental Homes

**Summary of an Expert Meeting Convened by the Maternal and Child Health
Bureau**

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Prepared for:

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I. Background, Overview, and Purpose

Promoting children's oral health is integral to the mission of the Federal Maternal and Child Health Bureau (MCHB) to improve the overall health and well-being of America's children, especially those at high risk for poor health outcomes. Of the various strategies used by MCHB to promote children's oral health, one of major ones has been to facilitate the delivery of dental sealants to school-aged children to protect against tooth decay and other resulting health and developmental problems.

Federal legislation passed in 1989 favored an enhanced role of MCHB and the maternal and child health community in promoting school-based sealant programs, especially for children served by Medicaid and State Children's Health Insurance Programs (SCHIP).¹ Subsequently, dental sealants were identified by a committee of key dental organizations and dental public health experts as the single most important oral health objective the MCHB and State MCH programs should track. In line with this focus on dental sealants, there has been a significant increase in recent years in MCH Block Grant support and activities allocated to State school-based dental sealant programs.

The MCHB has supported the development of sealant programs from the national level through numerous activities, including cosponsoring and funding dental sealant conferences; funding the American Association of Community Dental Programs (AACDP) to develop *Seal America: The Prevention Invention* (a "how-to" training manual and video about establishing or expanding school-based sealant programs); and supporting the initial development of a national school-based dental sealant data reporting and management system.

In addition, in 1999 MCHB established a discretionary school-based sealant grant program whose purposes included: (1) increasing school based sealant application in schools with 50 percent or more of its children in the free or reduced-price school lunch program; (2) ensuring that students receive follow-up care when necessary; and (3) ensuring that students are enrolled in Medicaid or State Children's Health Insurance Programs (SCHIP). (More detailed background information on MCHB's activities to promote sealants is included in Appendix A.)

In 2005, in the context of considering future directions for strengthening oral health systems of care, the MCHB identified a need to provide further direction to school-based sealant programs regarding how to address the latter two grant program goals identified above; this is, how to increase capacity for linking children to needed follow-up services, and enrolling them in public insurance programs through which dental services can be reimbursed. As a result of this identified need, in May 2006 MCHB convened an expert meeting to discuss strategies for strengthening school-based dental sealant program linkages with Medicaid/SCHIP and dental homes. This report summarizes discussions from this meeting.

¹ Language included in the 1989 Omnibus Reconciliation Act of 1989 (OBRA) identified the role of Title V programs in billing Medicaid for sealants, which were added for the first time as a covered service under Medicaid's Early and Periodic Screening, Diagnosis, and Treatment program. OBRA-89 also required State MCH programs to conduct statewide needs assessments and develop health plans to address identified needs, as well as assess progress in meeting national health goals and objectives.

Development, Overview, and Purpose of the Expert Meeting

The expert meeting was held on May 11-12, 2006 at the offices of Health Systems Research, Inc. (HSR) in Washington, DC, which provided support for the planning and conduct of the meeting. Throughout this process, the MCHB and HSR worked closely with a planning committee chaired by Dr. Gary Rozier, DDS, of the University of North Carolina at Chapel Hill School of Public Health and including representatives of Federal agencies, academia, public oral health programs, and private practice dentistry.²

Two objectives for the meeting were identified by the planning committee:

- Examine promising approaches, issues, and challenges faced by school-based dental sealant programs in enrolling eligible children in Medicaid/SCHIP and linking them to a dental home.
- Identify considerations and a menu of strategies³ – for inclusion as an appendix in the next update of *Seal America* and the development of policy briefs – for strengthening school-based dental sealant program linkages with community resources, including dental insurance and providers who can meet children’s broader oral health care needs.

To address these goals, the planning committee identified six programs (described further below) from across the country to share promising approaches for enrolling children in Medicaid/SCHIP and linking them to a dental home. Presenters, planning committee members, and other invited participants represented a cross-section of individuals from State and local oral health programs, professional dental associations, dental insurers, and academia.

The two-day meeting was moderated by Drs. Gary Rozier and Jim Crall. Day 1 of the meeting began with background presentations to set the context and featured the six programs identified to share promising practices. During Day 2, participants identified common elements to achieve success from the featured programs and identified strategies and considerations for linking children in school-based dental sealant programs to Medicaid/SCHIP and dental homes. (A participants list and meeting agenda are included in Appendix B and C, respectively.)

² Planning committee members in addition to the Chair (listed alphabetically) included: William Bailey of the Centers for Disease Control and Prevention, James Crall of the National Oral Health Policy Center at the University of California, Los Angeles (UCLA), A. Conan Davis of the Centers for Medicare and Medicaid Services, Lawrence Hill representing the American Association of Community Dental Programs, Beverly Largent representing the American Academy of Pediatric Dentistry, Lisa Phillips of the Arizona Department of Health Services, John Rossetti of the MCHB, and Captain Lee Shackelford representing the Academy of General Dentistry.

³ Given the variability across school-based sealant programs, the planning committee felt that the most appropriate role of this expert meeting was in identifying an array of possible strategies for programs to consider rather than more prescriptive recommendations.

II. Overview of Presentations

Dr. Mark Nehring of the MCHB and Dr. John Rossetti, Oral Health Consultant to the MCHB, opened the meeting by welcoming participants, discussing the meeting purpose, and providing background on MCHB sealant activities. The morning was devoted to two presentations that provided a context and framework for the meeting by discussing the role of dental sealant programs within the broader oral health community:

- William Bailey, DDS, MPH of the Centers for Disease Control and Prevention's (CDC) Division of Oral Health provided findings from a recent CDC expert meeting supporting the effectiveness of dental sealants in preventing pit-and-fissure decay and strongly recommending their use. Research on the effectiveness of school-based dental sealant programs in preventing dental caries was also discussed.⁴
- Jim Crall, DDS, ScD of the MCH Oral Health Policy Center at UCLA provided an overview of the dental home concept and implications for school-based dental sealant programs working to ensure access to comprehensive oral health care for school-age children.

The remainder of Day 1 featured presentations by the six identified programs from around the country with experience in linking children to dental homes and/or enrolling children in public health insurance programs whose experiences could inform the development of guidance for school-based sealant programs. As indicated by the brief descriptions provided below and in the descriptive table included in Appendix D, some of these programs are direct providers of sealants and other dental services, and others focus on linking children with services. Some are based in schools; others are not but have some linkage to schools.

- Steve Arthur, D.D.S., M.P.H., Vermont Department of Health, Vermont's Tooth Tutor Dental Access Program. This program employs a dental hygienist in elementary schools and Head Start/Early Head Start programs to conduct oral health screenings, provide dental education, and link children without a regular dentist to a dental home. The project is also training pediatricians to conduct oral health risk assessments as part of routine health exams.
- Karen Yoder, Ph.D., Indiana University School of Dental Medicine, SEAL INDIANA: Indiana University School of Dentistry Statewide Mobile Dental Sealant Program. This statewide mobile dental program provides preventive oral health services to children not receiving dental care. Services provided include dental sealants, oral examinations, x-rays, and fluoride varnish. Linking children to a dental home is one of the program goals, and efforts are made to enroll children in Medicaid or the State's SCHIP program.
- Jared Fine, D.D.S., M.P.H. and Jovita Kerner, R.D.H., M.A., Alameda County Health Department, Healthy Smiles Dental Program. Alameda County's program uses the

⁴ Truman, Gooch, & Sulemana et al. (*American Journal of Preventive Medicine*, 2002;23(1S)) have concluded that "the evidence is clear and convincing that sealants delivered through schools and school-affiliated clinics are safe and effective in preventing dental caries among children."

existence of a child's need for dental care as an opportunity to enroll the child and his or her family in health insurance. A health insurance specialist processes referrals of children identified by providers or schools (e.g., through school dental screenings) as needing dental treatment, provides assistance to enroll eligible children and their families in public or low-cost private insurance, and provides case management services to support their receipt of care by providers included in a network of contracted dentists.

- Michaela Granito-Tibbets, L.M.S.W., New Mexico Department of Health Children's Medical Services Dental Case Management Program. This pilot dental case management program in Sante Fe County provides intake, screening, and assessment services to referred children and their families and helps find them a dental home. The program supports multiple local dental clinics and programs, including school-based sealant programs, who work in partnership with the dental case management program to provide or link families with oral health services.
- Christine Veschusio, R.D.H., M.S., South Carolina Department of Health and Environmental Control's School Dental Prevention Program. Through this program, South Carolina operates dental programs in high risk school districts around the State. The programs offer varying scopes of dental preventives services, including but not limited to dental sealants. The programs rely heavily on Medicaid for funding; therefore, focus on Medicaid enrollment, including through the use of outreach workers in some program models. Outreach efforts are also conducted to link students with a dental home.
- Larry Hill, D.D.S., M.P.H. and Nancy Carter, R.D.H., M.P.H., Cincinnati Department of Health/Greater Cincinnati Oral Health Council School-linked Clinic and Mobile Dental Van. Cincinnati has utilized two primary models for increasing students' access to dental care, facilitating students' use of dental services provided through a corporate-sponsored dental clinic supported by private funds, and a mobile van supported with public and private funds. The programs aim to a broad spectrum of dental needs by providing diagnostic, preventive, and treatment services but also require linkages with community providers to provide needed backup care.

III. Key Themes

Several cross-cutting themes emerged from the expert meeting discussions. These provide an important backdrop to subsequent report sections which elaborate upon major issues facing school sealant programs in linking children to public insurance and dental homes, and strategies for addressing these challenges.

- Dental sealant programs are a stepping stone to improved oral health infrastructure. Dental sealant programs can help to broaden, and can serve as a stepping stone to enhancing the oral health infrastructure of a community by serving a vehicle for data collection about community needs, bolstered clinical capacity, a focal point for engaging communities in oral health, and training for dental professionals.
- Dental sealant programs are an important component of, and should be linked with, broader systems of care. School-based dental sealant programs are one component of a

broader system of care and, as such, should coordinate and have linkages with other system components, especially dental homes. Furthermore, given that oral health is critical to overall health and that the risk factors for poor oral health also put children at risk for other health and learning problems, efforts to improve oral health should be integrated with efforts and systems of care to meet children's broad needs.

- Further attention to defining and measuring dental homes is needed, especially within the context of serving high-risk families. While linking children to dental homes was a focus among highlighted programs, there was not consistency in how this term was applied or measured across programs. The operational definition of a dental home, and how it can be practically measured, was noted as an area for further refinement. Participants particularly stressed the need to consider how the concept of a dental home may be implemented within the context of dental sealant programs to accommodate the circumstances and needs of underserved communities.
- Care coordination, or case management, support is critical for engaging families and helping them navigate health care systems, but the relative costs and benefits of different approaches must be considered. To link children with oral health services available both through the schools and the broader community requires the active support and involvement of individuals who can obtain the trust of the parents/caregivers, convince them of the need for and value of services, and help them address the multiple steps involved in accessing care, including enrolling in insurance programs, making appointments, arranging transportation, and facilitating communication between families, schools, and community providers. Participants noted, however, that there are various approaches to providing this support and that the most expensive models are not necessarily required. Further information is felt to be needed regarding the costs and benefits of different approaches, especially regarding its use with high-risk populations.
- Political will and buy-in from the community and dental providers are critical for the support of school-based oral health programs. The importance of engaging community members, especially dental providers, in identifying needs and solutions and in efforts to secure resources to support school-based oral health promotion programs was a common theme in discussions. The schools (e.g., principal, school nurse, and teachers) must also have a high level of commitment to addressing the oral health needs of their students.

IV. Common Issues and Suggested Strategies for Improving Sealant Program Linkages with Community Resources, Including Public Insurance

Throughout the presentations of highlighted programs and subsequent discussions, participants identified a range of issues and factors that affect school sealant programs' ability to link children with dental homes and enroll them in public insurance programs. Comments related to these major issue areas are summarized briefly, followed by suggested strategies for addressing them. The issues and strategies, while overlapping in nature, are organized into 9 categories which reflect the organization of the meeting discussions: community awareness and support, scope of services, dental home linkages, relationships with local providers, financing, school commitment to oral health, outreach to families and coordination of care, program monitoring and evaluation, and program tools.

A. Community Awareness and Support

The importance of obtaining community support for sealant and related programs was a theme throughout the meeting discussions, as indicated above. Community support is needed throughout the many stages of a program's development and operation, for example, to craft a program that responds to community needs, to obtain needed resources, to provide feedback that can improve the program, and sustain it over time. Within the broad realm of "community," several types of key constituents were identified by participants including:

- Decision makers, such as policymakers and legislators, who can support policies and provide resources needed to establish and maintain school sealant programs
- Community leaders and coalitions, who understand community needs, engage community partners, and influence community policies and funding decisions
- Schools, through which students in need can be identified and reached
- Providers to deliver services to children and their families
- Families whom the program is intended to serve

These and other types of community supporters can be extremely effective advocates for the establishment and ongoing support of school-based sealant programs.

Given the central role of the schools in these programs, their commitment to oral health improvement programs is particularly critical. Presenters of highlighted programs stressed the role that principals, school nurses, and teachers play in establishing and facilitating the success of school-based or school-linked programs, including by encouraging family involvement and incorporating oral health education into the classrooms.

Strategies:

- Work with local oral health coalitions or other community coalitions and groups concerned about children's health. These coalitions can be critical advocates for resource allocation and policy support.
- Use data to tell the story of why the program is needed and how it will affect children's health and access to care.
- Identify and develop local champions who can market and advocate for the program.

B. Scope of Services

The scope of services provided through school-based oral health programs varies by community. In some, resources are focused on the delivery of dental sealants to underserved children – an approach which reflects a public health model of reaching a large number of children with limited resources.

The presentations at this meeting, however, highlighted the fact that school-based oral health programs are often not limited to dental sealants but, rather, frequently provide a broader range of dental services. Participants acknowledged the value of different approaches for different communities and found this variation to be consistent with the notion that dental sealants can serve as a stepping stone to broader care,

On the issue of what services are appropriate to include through a school-based program that provides dental sealants, participants emphasized that the range of services provided by any particular program should be driven by community needs and resources and, therefore, will vary by program. However, linkage to a dental home is believed to be a core element of program function,

Strategies:

- Base decisions about scope of services on community needs assessment data. Existing needs assessment data may be obtained from State or local health departments, and oral health data can be collected from the school population using such tools as the Basic Screening Survey.⁵
- Engage community members (including dental and other maternal and child health professionals) in decisions regarding what services are most appropriately and feasibly provided within school programs, what services are best provided through other community providers, and how to facilitate linkages between schools and other community providers.
- Consider titles – both for sealant programs and future editions of *Seal America* – that support the development of linkages between sealant-focused efforts and broader systems of care (e.g., “school-based dental programs” vs. “school-based sealant programs”).

C. Dental Home Linkages

Participants discussed definitions of medical and dental homes as developed by professional associations (e.g., American Academy of Pediatrics, American Academy of Pediatric Dentistry, American Dental Association) and considered the feasibility of implementing these concepts within the context of school-based sealant programs. While the concept of a dental home as envisioned by professional associations was well supported by meeting participants as a goal, the need to recognize limitations in achieving the ideal and identify flexible approaches for implementing the dental home concept was also stressed. More specifically, issues identified in implementing dental homes included:

- Insufficient availability of providers in the community to serve as dental homes, especially for children with Medicaid and for uninsured children. Refusal by providers to see clients after an appointment is missed further limits the pool of available providers.
- Unclear understanding/different perceptions regarding what constitutes a dental home (e.g., programs do not have a consistent definition of what a dental home is and how it should be

⁵ Information about this screening tool is available from the Association of State and Territorial Dental Directors at astdd.org.

measured, providers being asked to serve as dental home do not have a clear understanding of what that entails, families not using dental home in ways that providers or programs intend).

- The need to integrate the dental home concept into managed care systems organized around medical homes.
- The difficulty of encouraging families to utilize dental homes, even when referrals are made and providers are available. Cultural issues were noted as an important factor, specifically the applicability of a “middle class” dental home model to a high risk, culturally diverse population.
- Challenges of tracking what happens after a child is referred to a dental provider in the community, as information is often not shared back with the school about services that are provided (e.g., about further needs identified, future appointments, treatment plan completed).

Strategies:

- Seal America should include guidance to sealant programs regarding the definition of a dental home in the context of the challenges noted above and how it might be flexibly applied. For example:
 - Can you have a dental home without a dentist?
 - Can a school-based or school-linked program serve as a dental home?
- Establish referral and communication protocols between schools and community providers. For example, South Carolina provided an example of a dentist who provides restorative services to children identified by the school oral health program who signed a business agreement with the school so that information could be shared between the provider and school without violating privacy rules.
- Consider options for identifying children in need of dental homes. Highlighted programs described different approaches, ranging from reviewing information on health records/school forms (e.g., Vermont), depending on referrals from schools and providers and screening existing insurance databases (Alameda County), and extending services to all children in underserved schools (e.g., mobile vans in Cincinnati and Indiana).

D. Relationships with Local Providers

Among the issues discussed by meeting participants, relationships with community providers was one that garnered much focus and attention. As noted earlier, many programs experience a shortage of providers in their communities to serve children with treatment and other needs for ongoing care, impeding in their ability to facilitate children’s access to the range of needed oral health services and improve children’s oral, and overall, health. Representatives of dental provider associations and school programs at the meeting indicated several factors impacting this relationship:

- Challenges involved in ensuring that scheduled appointments will be kept

- Difficulties in communication between providers and patients who speak different languages
- Financing issues, including:
 - Inadequate reimbursement from Medicaid for procedures
 - Lack of insurance coverage for children not eligible for public insurance
 - Concern that Medicaid will not reimburse multiple providers who serve the same child within a short period of time
- Perceived competition over clients
- General disconnect between the worlds of public and private dentistry, especially because private providers generally do not see the level of need that exists in a very high risk population as part of their regular practice
- Concern related to meeting increased demand for services that will result from school-based programs' identification of children with needs beyond the scope of the programs.

Strategies:

- Personal recruitment of dentists, especially by dental professionals working in the schools, can be a promising strategy for engaging providers (e.g., Vermont's Tooth Tutor program has used dental hygienists in this role successfully).
- Work with local dental societies and other provider groups, especially during the program planning process to:
 - Encourage member buy in
 - Arrange referral protocols between schools and local providers, and identify other opportunities for provider involvement
 - Address concerns such as those related to perceived competition for patients (programs highlighted in this meeting targeted children without a dental home which, they note, increases opportunities for referrals to community dentists of new patients)
- Identify ways that the practicing community can act to impact the system and be an effective partner for public health. Providers with little public health exposure may benefit from basic training in public health.
- Offer experiences/training/volunteer opportunities that provide practicing providers and other community partners with insight into the population needs. These experiences offer opportunities to educate partners, create advocates, and obtain input into ways to strengthen the program.
- Provide dental professional students with service learning opportunities during their schooling (e.g., as done by the SEAL Indiana program) to expose them to the needs and provide experience in working with high risk populations. Although their involvement may

slow the service provision process, their involvement can encourage their ongoing commitment as practicing providers to serving high risk children.

- Cultivate relationships with Community/Migrant Health Centers, which focus on caring for underserved populations and are located within underserved areas.
- Provide support to families to help them schedule and keep dental appointments, such as through care coordination/case management approaches (discussed further below).
- Advocate, in collaboration with community coalitions, for higher Medicaid/SCHIP reimbursement rates and policies that allow multiple providers to bill for dental services to the same child within a limited time frame. These steps can be very helpful in facilitating successful referrals to community providers for needed care.

E. Financing

Financing is a critical issue facing school oral health programs. While the highlighted programs receive support through a variety of sources – Medicaid, Federal government and foundation grants, state funds (e.g., tobacco tax funds, public health monies), schools, and corporate donations – many challenges remain in establishing solid and ongoing financial support. Specific issues, some of which have been mentioned previously, include:

- Challenges related to Medicaid reimbursement, including:
 - Inadequate reimbursement levels to encourage provider involvement
 - Medicaid rules that do not permit multiple providers to bill for services to the same child within a given time period
- Lack of funding for undocumented children to receive routine dental care.
- Limited funding available to schools to help support school health promotion efforts such as those related to oral health.
- While donations of time by dental professionals for service delivery are highly valued, and highly beneficial for educating and engaging these providers in program and advocacy efforts, participants stressed that this is not a viable strategy for sustaining a program. To ensure their ongoing involvement, providers must receive adequate reimbursement for services provided.

Strategies:

- Integrate dental services into existing funding services/systems including Medicaid financed early intervention, school based centers, and community clinics.
- Utilize oral health coalitions to advocate for increased Medicaid reimbursements

- Look to foundations as a possible source of funding for program start-up costs. Explore opportunities to use foundation dollars to leverage other financial resources, such as Federal Medicaid match.
- Develop a business plan for program financing to pay for initial start-up costs and ongoing expenses including staffing, dental equipment and supplies, provider reimbursement, etc. Various sources of funding can be combined to support program activities and expenses.
- Use children’s need for dental care as a hook for encouraging insurance enrollment (as Alameda County has done with its Healthy Smiles Dental Program), which offers opportunities for provider reimbursement

F. Outreach to Families and Coordination of Care

Participants raised many challenges related to engaging families in oral health promotion activities and supporting them in navigating insurance and dental care systems. The value of a case management or care coordination approach was stressed for addressing many of the following needs:

- Supporting insurance enrollment and utilization. Families are often not aware of insurance options, need help in enrolling in available insurance programs (namely, Medicaid/SCHIP), and education and support regarding use of insurance that they do have (“in reach”).
- Serving diverse populations. The populations served by school-based dental programs typically serve families from various cultural backgrounds who speak multiple languages, including but not limited to Spanish. Programs and providers find it challenging to identify staff and materials to ensure that they can effectively communicate with children and their parents/caregivers.
- Obtaining parental consent for services. Obtaining consent for children to participate in oral screenings and other dental services can be a significant barrier to care due to such factors as:
 - Requirements related to privacy rules result in lengthy and complex consent forms that are difficult to understand, especially by low literacy populations
 - Parents often don’t return consent forms because they are not familiar with sealants, may be worried about risks involved, and/or think they will be charged for services
- Engaging parents in obtaining recommended services for their children. Once a school program has identified a child with follow-up dental care needs (e.g., who requires a visit to a community dentist or hospital-based program), engaging parents/caregivers to obtain that care for their children is often extremely difficult. These challenges exist even when the children have insurance and providers are available to deliver the needed care, prompting meeting participants to posit that dental care may not be highly valued enough by caregivers to warrant the additional steps needed to obtain the care.

- Funding and sustaining case managers, and to what end? While the importance of care coordination/case management services in providing support to families was stressed, there were also many related concerns, including:
 - Funding for case managers/care coordinators is difficult to obtain
 - High caseloads make the job a very challenging one and staff turnover is common
 - The costs for case management/care coordination services can be high
 - Resulting outcomes are often uncertain

Strategies:

- Provide support to families in navigating the health care system, including enrolling in insurance, utilizing insurance coverage, identifying providers, understanding and acting on oral health care needs, setting up appointments, and arranging transportation. However, in setting up these systems, recognize that there are alternative approaches for providing these services; varying levels of intensity, and use of different types of professional or lay staff, have varying levels of cost. Examples of approaches used in highlighted programs include:
 - South Carolina employs “patient navigators” who help to conduct outreach with families, track health care referrals link families with dental care, and keep all providers informed of treatment plans and progress, and other activities
 - Alameda County uses a health insurance specialist who also provides case management to enroll families in insurance programs and link them to dental homes. The program has high rates of success in clients keeping appointments (70-80% show rates for dental and insurance application appointments)
- Recognize the importance of focusing not just on the child but in working with the whole family to engage them in oral health promotion activities. New Mexico’s dental case management program takes this family approach and considers it to be a critical approach for engaging families in the dental care needs of their children.
- Utilize staff who speak Spanish and other languages spoken by families in the target population, both to effectively impart information regarding their child’s oral health but also, critically, to increase families’ comfort level and trust in the program and providers.
- In addition to speaking parents’ language, staff that have direct knowledge of the findings of the child’s specific dental needs can help to engage parents. New Mexico’s dental case manager, for example, is present during children’s dental screening, which allows her to impart firsthand knowledge to parents about their child’s needs. The SEAL Indiana program uses a bilingual dentist who works with its mobile van, has the child’s dental chart, and can discuss child’s condition when making follow-up calls to parents.
- Explore obtaining Medicaid administrative match for care coordination services provided through schools. Some States are investigating opportunities for school dental programs to obtain Medicaid reimbursement for Medicaid administrative functions such as case planning and coordination of care for a Medicaid eligible student (e.g., informing potentially eligible students about Medicaid and how to access it, assisting students/families in applying for Medicaid)

- Contact other local agencies to explore opportunities for coordination of dental care into existing care coordination/case management systems, including those for medical care and mental health, home visiting, and health advocacy services, but ensure that staff are educated about dental care needs and systems.
- Establish an end point for care coordination services and measures of efficiency.
- Strengthen education and outreach to families through such strategies as:
 - Placing dental hygienists in the schools to conduct outreach and education to families and linkage of children to dental homes (e.g., Vermont's Tooth Tutor program)
 - Placing outreach workers at community locations during evenings and weekends (e.g., a South Carolina school dental program places outreach workers at Wal-Mart)
- Explore strategies to facilitate the consent process such as:
 - Simplifying consent forms as much as possible and having them available in multiple languages
 - Motivating teachers about the importance of getting children to participate in dental programs, given their critical role in getting consent forms and other program information to and from homes
 - Considering options for using a passive consent approach to allowing children to receive dental screening (e.g., as Cincinnati's mobile van).

G. Program Monitoring and Evaluation

Despite the challenges involved, program monitoring and evaluation were identified as very important components of school-based sealant programs. Participants noted that the collection of program monitoring and evaluation data is critical to ongoing efforts to obtain program funding and can help to engage providers and other key stakeholders in program efforts. The SEAL Indiana program, for example, provides monthly data reports to the State health department to keep them informed of program activities and needs; this information flow is considered by the program to be important to maintaining and strengthening ties between the local and State levels.

The major focus of discussions on this topic, however, related to the need for data to be gathered from across programs to get a national picture of program reach, to able to compare programs and their impact, and to assess their effect on population level goals.

While participants agreed that programs need to be accountable for collecting data, they also stressed that:

- Expectations need to be reasonable

- National data collection efforts cannot wait until a perfect measure is identified; measures that can “point us in the right direction” must be identified and shared with sealant programs.

Strategies:

- The Seal America manual should include some recommended measures on which programs can collect data, especially related to dental home. These measures should be informed by:
 - Health services researchers
 - Dental epidemiologists
 - Participatory research that engages the community.

H. Program Tools

Meeting participants emphasized the importance of providing partners in school-based dental programs with practical tools for facilitating program success, either by sharing those that are in existence or, if needed, by developing new tools. Tools were noted as being needed to address numerous needs, including:

- Conducting needs assessments
- Assisting individuals without dental training in communicating basic and consistent oral health messages
- Training private practice dental providers regarding the needs of high risk populations and how they can be engaged in addressing these needs
- Facilitating communication between providers and clients speaking different languages⁶
- Fostering communication between dental providers in the community and the school about services needed and provided
- Providing care coordination/case management services, and sharing information on associated costs
- Leveraging resources
- Developing monitoring and evaluation approaches

⁶The University of the Pacific Arthur A. Dugoni School of Dentistry has developed a one-page health history form available in 34 languages at http://dental.pacific.edu/DentalPro/Health_History_Forms/default.htm.

V. Summary and Next Steps

In convening this meeting, the MCHB provided a unique forum for discussions regarding the role of school-based sealant programs within broader systems of care for children. Meeting participants identified a broad range of issues related to enhancing programs' roles in linking children to dental homes and enrolling them in public insurance programs, as well as strategies that can be used to address them.

The findings from this workshop will be used to guide the pending revision of the *Seal America* manual for school-based dental sealant programs, although participants acknowledged that many of the identified strategies will need to be further developed to be translated into practical guidance for sealant programs. Future efforts by MCHB to enhance and support the ongoing development of comprehensive oral health systems of care for children and their families will also be informed by the insight and lessons shared by those participating in this expert meeting.

Appendix A: MCHB Sealant Activities

Background: MCHB Sealant Activities*

Dental sealants have been a Title V (MCHB) Block Grant Program objective since 1989. The 1989 Omnibus Reconciliation Act of 1989 (OBRA) contained Title XIX: Medicaid and Title V: Maternal and Child Health legislative changes that favored the enhanced role of maternal and child health (MCH) in school-based sealant programs:

- Sealants were listed among the range of services covered under Early and Periodic Screening, Diagnosis, and Treatment for the first time.
- State MCH programs were required to conduct statewide needs assessments every 5 years and developed a health plan in response to assessments.
- MCH was required to assess progress in meeting national health goals and objectives, including Healthy People 2000 Health Objectives for the Nation.
- Section 1902(a)(11) and (22)(C) of the Social Security Act was changed to allow Title V funded programs to be the sole program allowed to bill for Medicaid services without having to bill other non-Medicaid recipients.
- Sealant appropriation language was contained in FY 1999 and FY 2000 MCHB budgets.

These changes were reinforced when dental sealants were selected by a committee of key dental organizations and dental public health experts as the single most important oral health objective the Bureau and State MCH programs should track. These changes resulted in a much greater participation of Federal, State, and local MCH in dental sealant programs. Over the past several years, there has been a significant increase in MCH Block Grant support and activities allocated to State school-based dental sealant programs.

As the Federal leader in access to school-based sealants for Medicaid/State Children's Health Insurance Program (SCHIP) and other underserved children, MCHB has sponsored and funded several projects, including the following:

- Cosponsored and funded a workshop to update science and standards of dental sealant delivery in public programs

Cosponsors included: W.K. Kellogg Foundation; MCHB; the Centers for Disease Control and Prevention; the National Institute of Dental Research; the Association for State and Territorial Dental Directors (ASTDD); the State University of New York; and Albany, NY.

- Cosponsored and funded two National Public Health Dental Sealant Conferences: Columbus, OH, in 1994 and Seattle, WA, in 1998.

Partners included: Department of Education, MCHB, ASTDD, the State of Ohio MCH Program, the Cincinnati Health Department, the American Fund for Dental

* Prepared by John Rossetti, D.D.S., M.P.H., for the May 11-12, 2006 MCHB-sponsored meeting, *Improving the Oral Health of School-Aged Children: Strengthening School-Based Dental Sealant Program Linkages with Medicaid/SCHIP and Medical Homes.*

Health, the W.K. Kellogg Foundation, the National Center for Education in Maternal and Child Health (NCEMCH), and the University of Illinois.

- Funded through the American Association of Community Dental Programs (AACDP) the development of *Seal America: The Prevention Invention*, a "how-to" training manual and video designed to assist those wishing to establish or expand their school-based sealant programs. The materials have been widely distributed through MCH Oral Health Resource Center (OHRC) at the NCEMCH.
- Funded the National School-Based Oral Health/Dental Sealant Resource Center at the University of Illinois–Chicago. At the end of the Center's grant period, a limited number of the functions of the center were transferred to the OHRC at the NCEMCH.
- Funded a training/technical assistance (T/TA) contract with the AACDP to provide T/TA to States and communities wishing to begin or expand existing dental sealant programs.
- Conducted a national, computer-based DataSpeak audioconference on the management and measurement of dental sealant sentinel data through the MCH Information Resource Center.
- Supported the initial development of a national school-based dental sealant data reporting and management system.
- Established a discretionary school-based sealant grant program in 1999. The purposes of the grants are to:
 1. Increase school based sealant application in schools with 50 percent or more of its children in the free or reduced-price school lunch program
 2. Ensure that students receive followup care when necessary
 3. Ensure that students are enrolled in Medicaid or SCHIP

Appendix B: Participant List



U.S. Department of Health and Human Services

*Health Resources and Services Administration
Maternal and Child Health Bureau*

Improving the Oral Health of School-Aged Children: Strengthening School-Based Dental Sealant Program Linkages with Medicaid/SCHIP and Dental Homes

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Appendix C: Agenda



U.S. Department of Health and Human Services

*Health Resources and Services Administration
Maternal and Child Health Bureau*

Improving the Oral Health of School-Aged Children: Strengthening School-Based Dental Sealant Program Linkages with Medicaid/SCHIP and Dental Homes

A Meeting of Health, School Health and Oral Health Experts to Examine the Role of School-Based Dental Sealant Programs in the Wider Oral Health Community

*Washington, DC
May 11-12, 2006*

Meeting Objectives:

- Examine promising approaches, issues, and challenges faced by school-based dental sealant programs in enrolling eligible children in Medicaid/SCHIP and linking them to a dental home.
- Identify considerations and a menu of strategies – for inclusion as an appendix in the next update of *Seal America* and the development of policy briefs – for strengthening school-based dental sealant program linkages with community resources, including dental insurance and providers who can meet children’s broader oral health care needs.

Thursday, May 11, 2006

9:00 am – 9:15 am

Welcome, Introductions, and Meeting Goals

- Mark Nehring, D.M.D., M.P.H., Maternal and Child Health Bureau
- John Rossetti, D.D.S., M.P.H., Oral Health Consultant

9:15 am – 10:45 am

Setting the Landscape: School-based Dental Sealant Programs and their Role in Improving the Oral Health of School-Aged Children

- Gary Rozier, D.D.S., M.P.H., University of North Carolina at Chapel Hill – Moderator
- William Bailey, D.D.S., M.P.H., Centers for Disease Control and Prevention
- Jim Crall, D.D.S., Sc.D., University of California, Los Angeles

This session will provide a framework for the meeting by discussing the role of dental sealant programs within the broader oral health community. Presenters will provide brief overviews of:

- Findings from a recent CDC expert meeting on the effectiveness of dental sealants
- Research on the effectiveness of school-based dental sealant programs in preventing dental caries
- An overview of the dental home concept and implications for school-based dental sealant programs working to ensure access to comprehensive oral health care for school-age children.

10:45 am – 11:00 am

Break

11:00 am – 12:30 pm

Promising Approaches for Enrolling Children in Medicaid/SCHIP and Linking them to Dental Homes: Panel I

- Steve Arthur, D.D.S., M.P.H., Vermont Department of Health
- Karen Yoder, Ph.D., Indiana University School of Dental Medicine
- Jovita Kerner, R.D.H., M.A.; Jared Fine, D.D.S., M.P.H., Alameda County Health Department

Speakers will provide a brief overview of their programs' approaches to enrolling eligible children in Medicaid/SCHIP and establishing a dental/medical home in the public or private sector. Challenges and lessons learned in achieving success will also be discussed. Ample time will be provided for discussion.

12:30 pm – 2:00 pm

Lunch on your own

2:00 pm – 3:30 pm

Promising Approaches for Enrolling Children in Medicaid/SCHIP and Linking them to Dental Homes: Panel II

- Michaela Granito-Tibbets, L.M.S.W., Santa Fe County Health Office
- Christine Veschusio, R.D.H., M.S., South Carolina Department of Health and Environmental Control
- Larry Hill, D.D.S., M.P.H.; Nancy Carter, R.D.H., M.P.H., Cincinnati Health Department

3:30 pm – 4:30 pm

Common Elements to Achieve Success

- Gary Rozier, D.D.S., M.P.H. – Moderator

In this session, participants will identify the common elements of sealant programs that appear to ensure success in attaining follow up care for children treated in a school- or community-based dental sealant program.

4:30 pm

Adjourn for the day

Friday, May 12, 2006

9:00 am – 10:00 am

Review of Previous Day's Discussion and Common Elements to Achieve Success (continued)

- John Rossetti, D.D.S., M.P.H.
- Gary Rozier, D.D.S., M.P.H.

10:00 am – 10:15 am

Break

10:15 am – 11:45 am

Strategies and Considerations

- Jim Crall, D.D.S., Sc.D.

Based on previous presentations and discussions, participants will identify issues to consider and viable strategies for linking children treated in school- or community-based dental sealant programs to Medicaid/SCHIP and a dental home.

10:45 am – 12:00 pm

Closing Remarks and Next Steps

- Mark Nehring, D.M.D., M.P.H.
- John Rossetti, D.D.S., M.P.H.

12:00 pm

Workshop Adjourns

Appendix D: Overview of Highlighted Programs

Overview of Highlighted Programs with Experience Linking Children to Dental Homes and/or Public Insurance

Program	Type of Program	Target Population	Financing	Service Provision	Insurance Enrollment	Linkage to Dental Home	Educational components
<p>Vermont Tooth Tutor Dental Access Program</p> <p>Pediatrician Office Pilot Project</p>	<p>School-based (elementary schools, Head Start, and Early Head Start)</p> <p>Pediatrician office-based</p>	<p>Children without a dental home, as identified through paper screening of school health history</p> <p>Large pediatric practice (University Pediatrics) in Burlington, VT</p>	<p>EPSDT</p> <p>Robert Wood Johnson, other foundations</p> <p>Schools</p> <p>State funds</p>	<p>Visual screening by dental hygienist for those children without a dental home (with parental consent)</p>	<p>Tooth tutors (school based and University Pediatrics) have responsibility to assess insurance and counsel families on availability of Vermont's two programs for low income individuals and families – Medicaid and Dr. Dynasaur (SCHIP)</p>	<p>School-based: Dental hygienist does outreach to local community dentists and refers children without a dental home to participating providers</p> <p>Pediatric office: Hygienist follows up with children at moderate to high risk to link with dental home</p>	<p>School-based dental health education for children K-6. Education of parents on importance of keeping appointments.</p> <p>Pediatrician office based pilot project to educate pediatricians and staff to include oral health risk assessment as part of normal health exam.</p>
<p>SEAL INDIANA: Statewide Mobile Dental Sealant Program</p>	<p>School-linked</p>	<p>Children who are not receiving dental care in Title I (lowest income) schools, Community Health Centers, migrant programs and Head Start</p>	<p>Start-Up: Indiana State Dept of Health (ISDH)</p> <p>Indiana University Purdue University Indianapolis - Research Investment Fund</p> <p>Ongoing: Medicaid FFS/sliding fee scale</p> <p>Grants from ISDH, HRSA, Anthem Foundation</p>	<p>Oral examination (with parental consent)</p> <p>Bitewing radiographs</p> <p>Sealants</p> <p>Fluoride varnish</p>	<p>Consent form has check box to receive information about public insurance</p> <p>Report to parents following care has a toll free number for State Health Department Wellness Helpline to find Medicaid providers and a toll-free number for Hoosier Healthwise (SCHIP)</p> <p>Telephone calls to parents of children with severe caries to provide information about eligibility/enrollment</p>	<p>Planned for full time care coordinator but unable to obtain funding to do so</p> <p>Bilingual dentist calls parents of children with severe caries to link with dental home and encourage insurance enrollment</p> <p>ISHD grant supports strategies to increase participation in SEAL Indiana and locate a dental home by (1) revision of the consent form,</p>	<p>Educational presentations are provided for classrooms by 4th year dental and 2nd year dental hygiene students during their required rotations with SEAL INDIANA</p>

Program	Type of Program	Target Population	Financing	Service Provision	Insurance Enrollment	Linkage to Dental Home	Educational components
SEAL INDIANA (Cont.)						and (2) staff for follow-up calls to parents	
Healthy Smiles Children's Dental Program, Alameda County, CA	School-linked (in that schools are one referral source for program clients)	Uninsured children in need of dental care. Children are identified by EPSDT providers and school dental screenings. 75% of the referrals are from the school screening; 25% are from EPSDT providers	Tobacco Tax pays for staff and reimbursement of network dentists In kind resources supported by Medicaid, EPSDT, MCH, and State general fund dental monies	Insurance enrollment, case management to network of dentists who are under contract to provide full range of primary care dental services.	Health insurance enrollment is a major focus of this program. Enrollment is conducted by a health Insurance Specialist (who also conducts case management).	Program contracts with a network of dentists who participate in Medicaid/SCHIP. Parents are notified of school screening findings. Then parents are called to schedule dental appointments within the network.	(Not the focus of this program.)
School Dental Prevention Program, South Carolina	School-based	Programs are targeted to schools with high risk of disease (e.g., economic need).	Medicaid reimbursement for services and for administrative functions such as case planning and coordination of care for Medicaid eligible students	Dental preventive services including oral hygiene instructions, oral prophylaxis, topical fluoride, dental sealants, dental radiographs (services vary by program, there are 9 programs in the state)	Focus on Medicaid enrollment. Staff has forms to send to parents, Medicaid has 800 line for staff to verify eligibility, many programs work with Medicaid directly to solve enrollment issues. Several programs utilize a dental outreach worker.	Provider lists send to parents and caregivers Phone calls and in some cases, home visits to parents/caregivers by dental hygienists, principals, guidance counselors, and school nurses Dentists agree to work with school dental programs and provide restorative care to students, dentist provides list of students seen in their office to the school dental program on a monthly basis	Individual and community education about the importance of oral health and benefits of dental sealants State Department of Education Oral Health Curriculum for Preschool, K, 2 nd and 7 th grades.

Program	Type of Program	Target Population	Financing	Service Provision	Insurance Enrollment	Linkage to Dental Home	Educational components
Dental Case Management Program, New Mexico Department of Health Children's Medical Services Pilot Program in Santa Fe County	School-linked (school dental screenings and clinics are an important source of program referrals)	Children and their families who need dental care. Referral can be made by anyone. Many are identified as part of Department of Health school dental screenings and sealant and a fluoride varnish clinic in which the case manager participates and helps coordinate.	HRSA grant supports case management function	Intake, referral and follow-up services, locating dental resources	Case manager is a presumptive eligibility/Medicaid on-site application assistance determiner. Assists families in filling out the Medicaid application and navigating the system once the application is at the Income Support Division. Presumptive eligibility is granted for 30 days while Medicaid processes the application. Also assists families in enrolling in other financial programs.	Community Resource Provider list is available to families. Meets in person with families or gives information over the phone. Refers clients to local clinics and to providers both contracted or volunteer.	Oral health education outreach in the community (e.g., Head Start family nights, WIC clinics, one on one with individuals and families); designs and distributes brochures
School-linked Clinic and Mobile Dental Van, Cincinnati, Ohio	School-linked	Clinic: All children in targeted schools receive consent form Van: Screenings done to identify children in grades k,1, 3, 5, 7	Clinic: -City of Cincinnati -Grant from local nonprofit (through community-based health center) -Procter and Gamble provided capital funding Mobile Van: -Ohio Dept of Health -Anthem Fndn of Ohio -Mayerson Fndn -United Way -Reimbursements	Diagnostic, preventive, and treatment services	Clinic: School partners work with families to enroll children in Medicaid Van: Information is sent home to parents of uninsured children	The clinic and van serve as the dental home, with backup from community providers during non-business hours	Individual clients receive anticipatory guidance/education as part of clinical care